# NYC District Council of Carpenters
# Welfare Fund
# Health Plan Enrollment Information

## PARTICIPANT INFORMATION:

| Name: | Social Security Number: | | UBC: |
|---|---|---|---|
| Street Address: | City, State & Zip: | | Date of Birth: |
| Home Phone: | Cell Phone: | Other Phone: | Email: |

## Dependent Information:

List **SPOUSE** that you wish to enroll and attach photocopies of marriage certificate, current relationship status and Social Security card. Include proof of Spouse's date of birth if not indicated on marriage certificate. Please include a photocopy of his/her Medicare card, if applicable.

| First Name | Last Name | Social Security Number | Date of Birth | Medicare Y/N? |
|---|---|---|---|---|
| | | | | |

List **DEPENDENT CHILDREN** and attach photocopy of birth certificate and social security card for each child. Please include copy of Medicare card, if applicable. Additional information may be required. If adding a Dependent Parent please enclose the appropriate documentation.

| First Name | Last Name | Social Security Number | Date of Birth | Medicare Y/N? |
|---|---|---|---|---|
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## CERTIFICATION

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**PARTICIPANT SIGNATURE** **DATE SIGNED**

**Please return this form, signed and dated, to the Fund Office**
**NYC District Council of Carpenters Welfare Fund**
**395 Hudson Street**
**New York, NY 10014**